VIBRANT FUTURES CACFP SPECIAL DIET STATEMENT

Dear Parent/Guardian:
Your provider participates in the Child and Adult Care Food Program (CACFP) and serves meals and snacks meeting the CACFP requirements. Food substitutions may be made only when supported by this statement. Return the completed form to your provider. If you have any questions, please contact me at 1-800-448-6995, ext. 223.

Sincerely,

Shelly Vondale, Director of CACFP at Vibrant Futures

PLEASE PRINT

Child's Name:	**Name of Child Care Provider:**
Name of Parent/Guardian:	**Parent/Guardian's Phone/Cell #:** ( ) - -

1. Check One (Refer to instructions on reverse side of this form):

☐ **The Child** has a disability* or a medical condition which requires a special meal or accommodation. Program operators are required to make reasonable substitutions to meals for participants with a disability/medical condition that restricts their diet on a case-by-case basis when signed by a **licensed physician (MD or DO), physician's assistant (PA), or nurse practitioner (NP) or registered dietician.**

☐ **The Child** is requesting a special meal or accommodations due to religious, cultural or personal preference. **Any substitution must fully meet the meal pattern.** Program operators are encouraged to make reasonable substitutions to meals on a case-by-case basis but are not required to do so. **A parent/guardian or adult participant may sign this request or a medical/healthcare professional may sign it.**

*The Americans with Disabilities Act (ADA) Amendment Act defines a person with a "disability" as any person who has a physical or mental impairment which substantially limits one or more "major life activities," has a record of such impairment, or is regarded as having such impairment **"Major life activities"** include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking breathing, learning, reading, concentrating, thinking, communicating, and working. Major life activities also include the operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.
USDA Policy Memorandum https://www.fns.usda.gov/cn/modifications-accommodate-disabilities-cacfp-and-sfsp

2. Foods to be omitted and substitutions: (*Please list specific foods to be omitted and suggested substitutions; you may attach a sheet with additional information as needed.)*

A. Food(s) To Be Omitted:	**B. Suggested Substitution(s)**

3. Briefly explain how exposure to those omitted foods affects the participant:

4. Indicate Texture:
☐ **Regular – if no modification needed** ☐ **Bite Sized Pieces** ☐ **Ground** ☐ **Tube Feeding**
☐ **Pureed** ☐ **Oral Feeding** ☐ **Other:**_____

5. Other Dietary Modifications or Additional Instructions (Describe):

6. Signature	**7. Printed Name (Include Credentials)**	**8. Telephone #**	**9. Date**

STATEMENT INSTRUCTIONS

Name of Child: Print the name of the child or adult participant to whom the information pertains.

Name of Child Care Provider: Print the name of the child care provider.

Name of Parent/Guardian: Print the name of the person requesting the participant's medical statement.

Parent/Guardian Telephone: Print the telephone number of parent or guardian, including area code.

1. **Check Only One:** Check a box ☐ to indicate whether a participant has a disability, or does not have a disability and is requesting special accommodations.
2. **Food(s) to be omitted and suggested substitution(s):** List specific foods that must be omitted. For example, "exclude fluid cow's milk." List the specific foods to include in the diet. For example, "nutritionally equivalent non-dairy beverage."
3. **List what occurs if the child is given an omitted Food.**
4. **Indicate texture:** Check a box ☐ to indicate the type of texture of food that is required. If the participant does not need any modification, check "Regular."
5. **Describe any other dietary Modifications or Additional Information and Instructions.**
6. **Signature:** Signature of person completing form.
7. **Printed Name:** Printed name of person completing form and credentials.
8. **Telephone:** Telephone number of person completing form.
9. **Date:** Date preparer signed form.

***The information on this form should be updated as necessary to reflect the current needs of the participant.**